

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 - 3 - 0 0 - 6

2. STATE:

Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

August 1, 2003

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.170

7. FEDERAL BUDGET IMPACT:

a. FFY 2003 \$ 0

b. FFY 2004 \$ 13,624

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, page 2b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-B, page 2b

10. SUBJECT OF AMENDMENT:

Reimbursement for hospice care

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Melanie Bella

13. TYPED NAME:

Melanie Bella

14. TITLE:

Assistant Secretary, Medicaid Policy & Planning

15. DATE SUBMITTED:

6/26/03

16. RETURN TO:

Melanie Bella, Assistant Secretary
Office of Medicaid Policy & Planning
402 W. Washington, Room W382
Indpls., IN 46204
ATTN: T. Brunner, State Plan Coordinator**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

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6/30/03

18. DATE APPROVED:

3/3/04

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

8/1/03

20. SIGNATURE OF REGIONAL OFFICIAL:

Cheryl A. Harris

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's health

23. REMARKS:

RECEIVED

JUN 30 2003

DMCH/ARA

HOSPICE SERVICES

Reimbursement for hospice care shall be made according to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the hospice wage index published by CMS.

Medicaid reimbursement for hospice services will be made at one of four all-inclusive per diem rates for each day in which a Medicaid recipient is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

- (1) Routine Home Care. The hospice will be paid at the routine home care rate for each day the recipient is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.
- (2) Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for over half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty four (24) hours a day.
- (3) Inpatient Respite Care. The hospice provider will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. For the day of discharge, the appropriate home care rate, routine or continuous, is paid unless the patient dies as an inpatient.
- (4) General Inpatient Care. Subject to the limitations below, the hospice provider will be paid at the general inpatient rate for each day the recipient is in an approved inpatient hospice facility and is receiving general inpatient care for pain control or acute or chronic symptom management which cannot be managed in other settings. For the day of discharge, the appropriate home care rate, routine or continuous, is paid unless the patient dies as an inpatient.

TN # 03-006

Supersedes

TN # 97-009Approval Date MAR 03 2004 Effective Date 8/1/03